

§ 413.241

based on the payment amounts determined under paragraph (a) of this section.

(3) ESRD facilities that become certified for Medicare participation and begin to provide renal dialysis services, as defined in § 413.171 of this part, between November 1, 2010 and December 31, 2010, must notify their designated MAC of their election choice at the time of enrollment.

(c) *Treatment of new ESRD facilities.* For renal dialysis services as defined in § 413.171, furnished during the transition period, new ESRD facilities as defined in § 413.171, are paid based on the per-treatment payment amount determined under § 413.215 of this part.

(d) *Transition budget-neutrality adjustment.* During the transition, CMS adjusts all payments, including payments under this section, under the ESRD prospective payment system so that the estimated total amount of payment equals the estimated total amount of payments that would otherwise occur without such a transition.

[75 FR 49201, Aug. 12, 2010]

§ 413.241 Pharmacy arrangements.

Effective January 1, 2011, an ESRD facility that enters into an arrangement with a pharmacy to furnish renal dialysis service drugs and biologicals must ensure that the pharmacy has the capability to provide all classes of renal dialysis service drugs and biologicals to patients in a timely manner.

[75 FR 49202, Aug. 12, 2010]

Subpart I—Prospectively Determined Payment Rates for Low-Volume Skilled Nursing Facilities, for Cost Reporting Periods Beginning Prior to July 1, 1998

SOURCE: 60 FR 37594, July 21, 1995, unless otherwise noted.

§ 413.300 Basis and scope.

(a) *Basis.* This subpart implements section 1888(d) of the Act, which provides for optional prospectively determined payment rates for qualified SNFs.

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(b) *Scope.* This subpart sets forth the eligibility criteria an SNF must meet to qualify, the process governing election of prospectively determined payment rates, and the basis and methodology for determining prospectively determined payment rates.

§ 413.302 Definitions.

For purposes of this subpart—

Area wage level means the average wage per hour for all classifications of employees as reported by health care facilities within a specified area.

Census region means one of the 9 census divisions, comprising the 50 States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

Routine capital-related costs means the capital-related costs, allowable for Medicare purposes (as described in subpart G of this part), that are allocated to the SNF participating inpatient routine service cost center as reported on the Medicare cost report.

Routine operating costs means the cost of regular room, dietary, and nursing services, and minor medical and surgical supplies for which a separate charge is not customarily made. It does not include the costs of ancillary services, capital-related costs, or, where appropriate, return on equity.

Rural area means any area outside an urban area in a census region.

Urban area means—

(1) Prior to October 1, 2004, a Metropolitan Statistical Area (MSA), or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as listed in § 412.62(f)(1)(ii)(B) of this chapter.

(2) Effective October 1, 2004, a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as specified under § 412.64.

[60 FR 37594, July 21, 1995, as amended at 69 FR 49265, Aug. 11, 2004]

§ 413.304 Eligibility for prospectively determined payment rates.

(a) *General rule.* An SNF is eligible to receive a prospectively determined

payment rate for a cost reporting period if it had fewer than 1,500 Medicare covered inpatient days as reported on a Medicare cost report in its immediately preceding cost reporting period. This criterion applies even if the SNF received a prospectively determined payment rate during the preceding cost reporting period.

(b) *Less than a full cost reporting period.* If the cost reporting period that precedes an SNF's request for prospectively determined payment is not a full cost reporting period, the SNF is eligible to receive prospectively determined payment rates only if the average daily Medicare census for the period (Medicare inpatient days divided by the total number of days in the cost reporting period) is not greater than 4.1.

(c) *Newly-participating SNFs.* An SNF is eligible to receive prospectively determined payment rates for its first cost reporting period for which it is approved to participate in Medicare.

§413.308 Rules governing election of prospectively determined payment rates.

(a) *Requirements.* An SNF must notify its intermediary at least 30 calendar days before the beginning of the cost reporting period for which it requests to receive such payment that it elects prospectively determined payment rates. A separate request must be made for each cost reporting period for which an SNF seeks prospectively determined payment. A newly participating SNF with no preceding cost reporting period must make its election within 30 days of its notification of approval to participate in Medicare.

(b) *Intermediary notice.* After evaluating an SNF's request for prospectively determined payment rates, the intermediary notifies the SNF in writing as to whether the SNF meets any of the eligibility criteria described in §413.304 and the timely election requirements under §413.308(a). The intermediary must notify the SNF of its initial and final determinations within 10 working days after it receives all the data necessary to make each determination. The intermediary's determination is limited to one cost reporting period.

(c) *Prohibition against revocation.* An SNF may not revoke its request after it has received the initial determination of eligibility from the intermediary and the cost reporting period has begun.

(d) *Revocation by intermediary.* If an SNF is given tentative approval to receive a prospectively determined payment rate, and, after the start of the applicable cost reporting period, the intermediary determines that the SNF does not meet the eligibility criteria, the intermediary must revoke the prospectively determined payment option.

§413.310 Basis of payment.

(a) *Method of payment.* Under the prospectively determined payment rate system, a qualified SNF receives a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. Each SNF's routine per diem payment rate is determined according to the methodology described in §413.312 and is based on various components of SNF costs.

(b) *Payment in full.* The payment rate represents payment in full for routine services as described in §413.314 (subject to applicable coinsurance as described in subpart G of part 409 of this title), and for routine capital costs. Payment is made in lieu of payment on a reasonable cost basis for routine services and for routine capital costs.

§413.312 Methodology for calculating rates.

(a) *Data used.* (1) To calculate the prospectively determined payment rates, CMS uses:

(i) The SNF cost data that were used to develop the applicable routine service cost limits;

(ii) A wage index to adjust for area wage differences; and

(iii) The most recent projections of increases in the costs from the SNF market basket index.

(2) In the annual schedule of rates published in the FEDERAL REGISTER under the authority of §413.320, CMS announces the wage index and the annual percentage increases in the market basket used in the calculation of the rates.

(b) *Calculation of per diem rate—(1) Routine operating component of rate—(i)*